

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No
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Requestor's Name and Address San Antonio Accident & Injury Center 401 W. Commerce, #100 San Antonio, TX 78207	MDR Tracking No.: M4-04-2411-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address City of San Antonio c/o Harris & Harris P.O. Box 162443 Austin, TX 78716	Date of Injury:
	Employer's Name: City of San Antonio
	Insurance Carrier's No.: 0027847456

Dates of Service	1997-1998	1998-1999	1999-2000
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From	To	CPT Code(s) or Description	Amount in Dispute	Amount Due
06/10/03	06/30/03	CPT Codes: 99213, 97032, 97124, 97116, 97112, 97265,	\$1,428.00	\$384.00

Position Summary dated 09/08/03 states in part, "...The bills were denied because payment was reduced because the documentation does not state what area

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a Position Summary with their response.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of \$384.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

03-04-05

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____